

		FOR OHF USE					

LL 1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0035683</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>St. Anthony's Continuing Care</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/00</u> to <u>9/30/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>767 30th Street</u> <u>Rock Island</u> <u>61201</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Rock Island</u>		Officer or Administrator of Provider (Signed) _____ <u>2/1/02</u> (Type or Print Name) <u>Daniel E. Baker</u> (Date)																									
Telephone Number: <u>(309) 788-7631</u> Fax # <u>(309) 788-9823</u>		(Title) <u>Chief Financial Officer</u>																									
IDPA ID Number: <u>36-3669284-001</u>		(Signed) _____ (Date)																									
Date of Initial License for Current Owners: <u>5/1/74</u>		Paid Preparer (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()																									
Type of Ownership: <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																									
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																									
	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																									
	<input type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
IRS Exemption Code <u>501(C)3</u>																											
In the event there are further questions about this report, please contact: Name: <u>Michelle Carrothers</u> Telephone Number: <u>(309) 655-2873</u>																											

STATE OF ILLINOIS

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Facility Name & ID Number St. Anthony's Continuing Care# 0035683 Report Period Beginning: 10/1/00 Ending: 9/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>42</u>	Skilled (SNF)	<u>42</u>	<u>15,330</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>78</u>	Intermediate (ICF)	<u>78</u>	<u>28,470</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,309</u>	<u>3,961</u>	<u>2,450</u>	<u>12,720</u>	8
9	SNF/PED					9
10	ICF	<u>11,173</u>	<u>15,175</u>		<u>26,348</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,482</u>	<u>19,136</u>	<u>2,450</u>	<u>39,068</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 89.20%D. How many bed-hold days during this year were paid by Public Aid?

(Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
_____F. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 5/1/74J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 42 and days of care provided 2,298Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 9/30/01 Fiscal Year: 9/30/01
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

St. Anthony's Continuing Care

0035683

Report Period Beginning:

10/1/00

Ending:

9/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	221,782	20,249	6,634	248,665		248,665		248,665			1
2	Food Purchase		135,869		135,869		135,869	(1,171)	134,698			2
3	Housekeeping	121,823	11,649	9,384	142,856		142,856		142,856			3
4	Laundry	26,336	20,168	136,302	182,806		182,806		182,806			4
5	Heat and Other Utilities			264,060	264,060		264,060	(6,866)	257,194			5
6	Maintenance	156,714	23,410	105,608	285,732		285,732		285,732			6
7	Other (specify):*											7
8	TOTAL General Services	526,655	211,345	521,988	1,259,988		1,259,988	(8,037)	1,251,951			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,218,039	120,032	341,548	1,679,619		1,679,619	(122)	1,679,497			10
10a	Therapy	23,761	4,168	70,474	98,403		98,403		98,403			10a
11	Activities	61,470	907	363	62,740		62,740		62,740			11
12	Social Services	29,709	884	12,588	43,181		43,181		43,181			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*			1,904	1,904		1,904		1,904			15
16	TOTAL Health Care and Programs	1,332,979	125,991	426,877	1,885,847		1,885,847	(122)	1,885,725			16
	C. General Administration											
17	Administrative	46,400		164,026	210,426		210,426		210,426			17
18	Directors Fees											18
19	Professional Services			60,921	60,921		60,921		60,921			19
20	Dues, Fees, Subscriptions & Promotions			4,615	4,615		4,615		4,615			20
21	Clerical & General Office Expenses	237,173	7,909	37,096	282,178		282,178	(9,916)	272,262			21
22	Employee Benefits & Payroll Taxes			687,612	687,612		687,612		687,612			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,974	5,974		5,974		5,974			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			5,387	5,387		5,387	(1,141)	4,246			26
27	Other (specify):*	37,547	45	10,979	48,571		48,571		48,571			27
28	TOTAL General Administration	321,120	7,954	976,610	1,305,684		1,305,684	(11,057)	1,294,627			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,180,754	345,290	1,925,475	4,451,519		4,451,519	(19,216)	4,432,303			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number

St. Anthony's Continuing Care

#0035683

Report Period Beginning:

10/1/00

Ending:

9/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			355,530	355,530		355,530	(39,223)	316,307			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,046	33,046		33,046	(312)	32,734			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,310	7,310		7,310		7,310			35
36	Other (specify):*											36
37	TOTAL Ownership			395,886	395,886		395,886	(39,535)	356,351			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,550	21,600	24,150		24,150		24,150			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		2,550	87,300	89,850		89,850		89,850			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,180,754	347,840	2,408,661	4,937,255		4,937,255	(58,751)	4,878,504			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number St. Anthony's Continuing Care

0035683

Report Period Beginning: 10/1/00

Ending: 9/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,171)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(2,059)	30		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(228)	30		9
10	Interest and Other Investment Income	(312)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(122)	10		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(36,936)	30		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,916)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,141)	26		28
29	Other-Attach Schedule <u>Non Care Utilities</u>	(6,866)	5		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (58,751)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (58,751)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

St. Anthony's Continuing Care

ID# 0035683

Report Period Beginning: 10/1/00

Ending: 9/30/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St. Anthony's Continuing Care

0035683

Report Period Beginning:

10/1/00

Ending:

9/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,171)	0	0	0	0	0	0	0	0	0	0	(1,171)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,171)	0	0	0	0	0	0	0	0	0	0	(1,171)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(122)	0	0	0	0	0	0	0	0	0	0	(122)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(122)	0	0	0	0	0	0	0	0	0	0	(122)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(9,916)	0	0	0	0	0	0	0	0	0	0	(9,916)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(1,141)	0	0	0	0	0	0	0	0	0	0	(1,141)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(11,057)	0	0	0	0	0	0	0	0	0	0	(11,057)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(12,350)	0	0	0	0	0	0	0	0	0	0	(12,350)	29

Summary B

9/30/01

[illegible]

Facility Name & ID Number St. Anthony's Continuing Care# 0035683

Report Period Beginning:

10/1/00

Ending:

9/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
OSF Healthcare System	100			See attached schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	6 Engineering&Mat Mgmt	\$ 18,338	OSF Healthcare System	100.00%	\$ 18,338	\$
2	V	10 Quality Assurance	964			964	
3	V	17 Accounting	16,076			16,076	
4	V	17 Administration	45,987			45,987	
5	V	21 Human Resources	4,110			4,110	
6	V	33 Corporate Financing	33,046			33,046	
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 118,521			\$ 118,521	\$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St. Anthony's Continuing Care # 0035683 Report Period Beginning: 10/1/00 Ending: 9/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St. Anthony's Continuing Care # 0035683 Report Period Beginning: 10/1/00 Ending: 9/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

B Real Estate Taxes		<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>			
1.	Real Estate Tax accrual used on 2000 report.	\$			1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$			2
3.	Under or (over) accrual (line 2 minus line 1).	\$			3
4.	Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <div style="color: red;">(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</div>	\$			5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <div style="display: flex; justify-content: space-between;"> TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.) </div>	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$			7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1996		8
	1997		9
	1998		10
	1999		11
	2000		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$		16

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St. Anthony's Continuing Care COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0035683

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:

109,490

B. General Construction Type:

Exterior

Brick

Frame

Concrete & Steel

Number of Stories

5

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Care Related	319,300		\$ 184,600	1
2					2
3	TOTALS	319,300		\$ 184,600	3

Facility Name & ID Number St. Anthony's Continuing Care

0035683

Report Period Beginning:

10/1/00

Ending:

9/30/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	183		1974	1974	\$ 2,112,437	\$ 70,415	30	\$ 70,415		\$ 1,900,003	4
5			1990	1990	951,769	31,726	30	31,726		362,205	5
6			1974	1974	990,506	33,017	30	33,017		895,556	6
7			1975	1975	125,361	4,179	30		(4,179)	73,132	7
8			1976	1976	1,529	51	30		(51)	836	8
	Improvement Type**										
9	Elevator			1978	626		10			626	9
10	Roofing			1978	1,723		10			1,723	10
11	Sprinkler System			1980	5,244		10			5,244	11
12	Roof			1981	49,993		10			49,993	12
13	Air Conditioning			1981	21,255		10			21,255	13
14	Electrical System			1981	18,184		15			18,184	14
15	Heat/Water/Lights			1982	15,029		15			15,029	15
16	Waterproofing			1981	4,029		5			4,029	16
17	Ceiling			1982	3,372		15			3,372	17
18	Asphalt			1982	11,642		15			11,642	18
19	Tracal Roof			1982	12,157		10			12,157	19
20	Hospice Room			1983	933		10			933	20
21	Storm Windows			1983	19,642		5			19,642	21
22	Carpeting			1982	12,197		5			12,197	22
23	Smoke Detector			1983	3,270		5			3,270	23
24	Smoke Detector			1984	261		5			261	24
25	Lights			1985	1,674		5			1,674	25
26	Elevator			1984	3,165		3			3,165	26
27	Central Air Units			1986	221,217		10			221,217	27
28	Waterproofing			1984	5,500		10			5,500	28
29	A/C Kitchen			1987	30,196		10			30,196	29
30	P/T Air Cond Unit			1988	2,950		10			2,950	30
31	Boiler Roof			1988	7,274		10			7,274	31
32	Window Painting			1988	10,050		5			10,050	32
33	Heater Tank			1988	28,778	1,919	15	1,919		24,947	33
34	Elevator Motor			1989	3,107		10			3,107	34
35	Dietary Roof			1980	3,939		5			3,939	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number St. Anthony's Continuing Care

0035683

Report Period Beginning:

10/1/00

Ending:

9/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Boiler Repair	1981	\$ 4,871	\$	5	\$	\$	\$ 4,871	37	
38	Irrigation System	1983	730		5			730	38	
39	Plants/Trees/Topsoil	1989	6,248		10			6,248	39	
40	Plants/Trees/Topsoil	1990	1,690		10			1,690	40	
41	Plants/Trees/Topsoil	1990	5,265		10			5,265	41	
42	Landscaping	1990	2,202		10			2,202	42	
43	Architect Services	1991	2,400	120	20	120		1,260	43	
44	Condensate Pump	1991	3,240	162	10	162		3,240	44	
45	Fire Doors-Tunnel	1991	9,663	483	20	483		5,072	45	
46	Duct Work/Dampers	1991	3,340	167	20	167		1,754	46	
47	Roof	1991	57,495	2,870	10	2,870		57,495	47	
48	Fire Doors	1991	1,812	91	20	91		955	48	
49	Radiator Valves	1991	3,710	186	20	186		1,953	49	
50	Hot Water Converters	1991	2,481	124	20	124		1,302	50	
51	Signage	1991	674	56	12	56		588	51	
52	Fire Alarm System	1991	609		15	41	41	430	52	
53	Convert Hot Water	1991	4,979	249	20	249		2,614	53	
54	Radiator Valves	1992	282	15	20	14	(1)	133	54	
55	Curtain Tracks	1992	7,386	1,477	10	739	(738)	7,020	55	
56	Fire Alarm System	1992			15				56	
57	Boiler Controls	1992	25,406	1,337	10	2,541	1,204	24,139	57	
58	Heat Exchanger	1992	16,850	887	20	843	(44)	8,008	58	
59	IDPA Adjustment	1989	2,655		10	(5)	(5)	2,655	59	
60	IDPA Adjustment	1990	33,338		10			33,338	60	
61	Remodel 3rd Floor	1976	5,240		20			5,240	61	
62	Remodel 3rd Floor	1992	158,877		30	5,296	5,296	47,664	62	
63	Kitchen Roof Repair	1993	27,440	2,744	10	2,744		23,328	63	
64									64	
65									65	
66									66	
67									67	
68									68	
69									69	
70	TOTAL (lines 4 thru 69)		\$ 5,067,892	\$ 152,275		\$ 153,798	\$ 1,523	\$ 3,974,502	70	

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	2 Year Constructed	3 Cost	4 Current Book Depreciation	5 Life in Years	6 Straight Line Depreciation	7 Adjustments	8 Accumulated Depreciation	9
1	Totals from Page 12A, Carried Forward		\$ 5,067,892	\$ 152,275		\$ 153,798	\$ 1,523	\$ 3,974,502	1
2	Exchangers	1993	1,060	59	18	59		502	2
3	Doors	1993	15,730	1,049	15	1,049		8,918	3
4	Curtains	1993	20,152		5			20,152	4
5	Repair	1993	848	47	18	47		400	5
6	Automatic Door	1993	10,807	1,080	10	1,081	1	9,190	6
7	System	1993	4,956	330	15	330		2,806	7
8	Coil Units	1993	3,750	250	15	250		2,125	8
9	Floor Remodel	1993	113,495	11,618	12	9,458	(2,160)	80,406	9
10	Alarm	1993	187,359	13,718	13	14,412	694	122,522	10
11	Landscaping	1993	5,789	579	10	579		4,922	11
12	Curtains	1994	534		5			534	12
13	Fire Alarm	1993	827	49	17	49		367	13
14	Replace Roof 1936 Bldg	1994	61,019	6,102	10	6,102		39,663	14
15	Electric Upgrade-Washers	1993	1,850	115	16	115		748	15
16	Handicapped Door Unit	1995	8,524	852	10	852		5,538	16
17	Draperies	1995	4,462	448	5	448		4,910	17
18	Patient Wandering System	1995	21,218	2,122	10	2,122		13,793	18
19	Electrical Distribution Panel	1995	2,650	166	16	166		1,079	19
20	Carriage House Prk Lot Lites	1996	528	36	15	36		198	20
21	Patient Wandering System	1996	7,098	710	10	710		3,905	21
22	Plumbing Work-Laundry	1996	5,820	291	20	291		1,601	22
23	Upgrade Telephone System	1996	38,092	3,809	10	3,809		20,950	23
24	Custom Built Workstation	1996	1,619	81	20	81		486	24
25	Air Condition Sys-Lobby	1996	13,575	1,358	10	1,358		7,469	25
26	2nd Floor Renovation	1996	652,169	32,608	20	32,608		195,648	26
27	2nd Floor Renovation	1996	16,031	1	5	1		16,081	27
28	2nd Floor Renovation	1996	22,536	2,254	10	2,254		13,524	28
29	2nd Floor Renovation	1996	681	42	15	42		252	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,291,071	\$ 232,049		\$ 232,107	\$ 58	\$ 4,553,191	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,291,071	\$ 232,049		\$ 232,107	\$ 58	\$ 4,553,191	1
2	Visitors Parking Lighting	1997	3,880	258	15	258		1,161	2
3	Carriage House Park Lights	1997	1,580	106	15	106		477	3
4	Carriage House Parking Blacktop	1997	22,900	2,862	8	2,862		12,879	4
5	Visitors Parking Blacktop	1997	26,525	3,316	8	3,316		14,922	5
6	Carpet-Conference Room	1997	4,632	926	5	926		4,167	6
7	TV Cable/Antenna System	1997	30,000	3,000	10	3,000		13,500	7
8	Door Latches-Resident Rooms	1997	26,383	1,320	20	1,320		5,940	8
9	2 Auto Doors to Patio	1997	18,167	1,816	10	1,816		8,172	9
10	Upgrade Water Svc 1952 Bldg.	1997	11,150	558	20	558		2,511	10
11	Kitchen Elevator Upgrade	1997	47,424	2,372	20	2,372		10,674	11
12	Chapel Sound System	1998	2,853	286	10		(286)		12
13	Upgrade Water Service 1952 Bldg.	1998	559	28	20	28		84	13
14	Automatic Door-Ambulance Entrance	1998	10,975	1,098	10	1,098		3,294	14
15	Emergency Generator	1999	282,840	14,142	20	14,142		30,641	15
16	Emergency Generator	1999	526	26	20	26		52	16
17	Sprinkler System-Fire Alarm	2000	6,981	465	10	465		930	17
18	Sprinkler System-General Bldg.	2000	424,156	14,139	20	14,139		28,278	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,212,602	\$ 278,767		\$ 278,539	\$ (228)	\$ 4,690,873	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 388,673	\$ 45,028	\$ 45,028	\$	Various	\$ 225,970	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	493,544				Various	493,544	73
74								74
75	TOTALS	\$ 882,217	\$ 45,028	\$ 45,028	\$		\$ 719,514	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,279,419	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 323,795	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 323,567	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (228)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,410,387	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Chapel/Storage	\$ 415,615	\$ 13,854	\$ 378,520	86
87	Riverside ? Annex	692,467	23,082	630,553	87
88	Carriage House Assets	65,188		65,188	88
89	Chapel Windows	5,771		5,771	89
90	Chapel ?	7,240		7,240	90
91	TOTALS	\$ 1,186,281	\$ 36,936	\$ 1,087,272	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ _____

13. /2003 \$ _____

14. /2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits		567	21,600		567	21,600		5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$	567	\$ 21,600	\$	567	\$ 21,600		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 80,052	\$	1
2	Cash-Patient Deposits	11,731		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	673,823		3
4	Supply Inventory (priced at)	46,259		4
5	Short-Term Investments			5
6	Prepaid Insurance	4,654		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 816,519	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	184,600		14
15	Leasehold Improvements, at Historical Cost	7,820,378		15
16	Equipment, at Historical Cost	90,663		16
17	Accumulated Depreciation (book methods)	882,217		17
18	Deferred Charges	(6,486,408)		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	3,030,791		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Impairment of Assets	(2,400,000)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,122,241	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,938,760	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 100,851	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,855		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	383,183		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,268		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 519,157	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 519,157	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,419,603	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,938,760	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,881,770	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,881,770	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,443,348)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) Reduction in Temp Restricted Funds	(18,819)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,462,167)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,419,603	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,558,255	1
2	Discounts and Allowances for all Levels	(1,111,292)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,446,963	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	236,960	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 236,960	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	642	12
13	Barber and Beauty Care	2,059	13
14	Non-Patient Meals	817	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	122	21
22	Laundry	4,951	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 8,591	23
D. Non-Operating Revenue			
24	Contributions	27,581	24
25	Interest and Other Investment Income***	173,815	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 201,396	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,893,910	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,259,988	31
32	Health Care	1,885,847	32
33	General Administration	1,305,684	33
B. Capital Expense			
34	Ownership	395,886	34
C. Ancillary Expense			
35	Special Cost Centers	24,150	35
36	Provider Participation Fee	65,700	36
D. Other Expenses (specify):			
37	Impairment of Assets	2,400,000	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,337,255	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,443,345)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,443,345)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number St. Anthony's Continuing Care# 0035683Report Period Beginning: 10/1/00Ending: 9/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,933	2,086	\$ 41,627	\$ 19.96	1
2	Assistant Director of Nursing	238	246	5,114	20.79	2
3	Registered Nurses	12,452	13,120	250,481	19.09	3
4	Licensed Practical Nurses	25,476	27,572	349,537	12.68	4
5	Nurse Aides & Orderlies	52,078	55,747	524,648	9.41	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,901	2,078	23,761	11.43	8
9	Activity Director	1,700	1,962	24,604	12.54	9
10	Activity Assistants	4,829	5,462	36,867	6.75	10
11	Social Service Workers	1,729	1,752	29,709	16.96	11
12	Dietician	3,729	3,932	61,740	15.70	12
13	Food Service Supervisor					13
14	Head Cook	6,310	6,713	47,274	7.04	14
15	Cook Helpers/Assistants	18,334	19,441	122,322	6.29	15
16	Dishwashers					16
17	Maintenance Workers	14,425	16,060	159,165	9.91	17
18	Housekeepers	16,001	16,900	121,823	7.21	18
19	Laundry	4,054	4,380	34,819	7.95	19
20	Administrator					20
21	Assistant Administrator	1,894	1,902	46,400	24.40	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,631	5,889	74,292	12.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	31	31	2,328	75.10	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,977	2,185	26,143	11.96	31
32	Other Health Care(specify)					32
33	Other(specify)	4,451	4,451	48,099	10.81	33
34	TOTAL (lines 1 - 33)	179,173	191,909	\$ 2,030,753 *	\$ 10.58	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	240	\$ 6,214	1.3	35
36	Medical Director				36
37	Medical Records Consultant	14	405	12.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	1,457	34,281	10.3	40
41	Occupational Therapy Consultant	1,427	33,673	10.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	64	2,520	10.3	43
44	Activity Consultant	6	363	11.3	44
45	Social Service Consultant	7	363	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,215	\$ 77,819		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	57	\$ 2,010	10.3	50
51	Licensed Practical Nurses	2,684	88,211	10.3	51
52	Nurse Aides	12,796	248,783	10.3	52
53	TOTAL (lines 50 - 52)	15,537	\$ 339,004		53

Facility Name & ID Number St. Anthony's Continuing Care# 0035683Report Period Beginning: 10/1/00Ending: 9/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	Amount	D. Employee Benefits and Payroll Taxes			Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function	%			Description			Description			
Eileen Mosley	Asst Admin	0	\$	46,400	Workers' Compensation Insurance	\$	30,329	IDPH License Fee	\$		
					Unemployment Compensation Insurance			Advertising: Employee Recruitment			
					FICA Taxes		152,572	Health Care Worker Background Check			
					Employee Health Insurance		442,511	(Indicate # of checks performed _____)			
					Employee Meals			Licenses		583	
					Illinois Municipal Retirement Fund (IMRF)*			INHAA		75	
					Vacations		8,730	CHA		175	
					TSP Contributions		14,058	Life Services Network		3,730	
					Pension Plan Contributions		36,000	Miscellaneous		10	
					Employee Physicals		372	The Institute (Training Manual)		42	
					Employee Assistance		1,756	Less: Public Relations Expense	(
					Fringe Benefits-Other		1,284	Non-allowable advertising	(
								Yellow page advertising	(
TOTAL (agree to Schedule V, line 17, col. 1)					TOTAL (agree to Schedule V,			\$	TOTAL (agree to Sch. V,		\$
(List each licensed administrator separately.)				\$	line 22, col.8)				line 20, col. 8)		
				46,400				687,612			4,615
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**			
					to Owners or Employees						
Description			Amount		Description	Line #	Amount	Description		Amount	
Corporate Office Charges			\$	62,063			\$	Out-of-State Travel	\$	484	
Administrator (Heritage Corporation)				96,000							
Benedictine Health Systems				725				In-State Travel		2,720	
Expense Auditorium Which Was Abandoned				5,238							
TOTAL (agree to Schedule V, line 17, col. 3)			\$	164,026				Seminar Expense		2,770	
(Attach a copy of any management service agreement)											
C. Professional Services					TOTAL			\$	Entertainment Expense		(
Vendor/Payee	Type		Amount						(agree to Sch. V,		
KPMG	Audit		\$	3,500					line 24, col. 8)		\$
Larson, Allen, Wershaw & Co	Feasibility Study for			10,000							5,974
	Sale of Provider										
Hinshaw & Culbertson	Legal Invoices			47,421							
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL			\$			
(If total legal fees exceed \$2500 attach copy of invoices.)				\$							
				60,921							

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN \$3730- INHAA \$75
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7.51 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,940 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 65,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,171
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? _____
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG Peat Mavreck The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.